MedBen Work Instruction
Appeals Processing – Mutual

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Department Covered by Work Instruction	Claims Processing
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Approved by:	Bobbie Painter
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Purpose of Work Statement
The purpose of this work instruction is to describe the workflow and turnaround time limits for the handling of mutual appeal request.

Inputs
Each appeal that is received by MedBen is first routed to and logged by the Executive Administrator. The Executive Administrator date stamps the document and retains a copy until disposition is received.

Once the appeal has been logged into the central area, the appeal is placed in a folder for a team member from the data prep department who retrieves the appeals. Each appeal is then scanned and indexed to the claim number being appealed. During the indexing process an electronic documentation record is created and routed to the Appeals Coordinator.

The Indiana Department of Insurance requires the following timeframes to be met:
- The insured has 120 days to file an external appeal
- Send written acknowledgement of appeal within 5 business days of receipt
- Appeal must be resolved within 45 business days of date filed (receipt)
- Regardless of the timeframes above, we must notify the member within 5 business days of making the determination on the appeal
- All costs of an external review are to be paid by MedBen

Other states may have different requirements. Refer to the Department of Insurance website for that specific state for specific requirements.

Process
1) Daily, the Appeals Coordinator (AC) reviews documentation records for new appeal requests (reason code 23) and the appeals spreadsheet is updated. The appeals spreadsheet can be found at Claims TPA/AppealDocuments/Appeals log

2) Initial assessment occurs during the first review by the AC. An initial assessment includes a review regarding the appropriateness of the appeal as determined in the appeals section of the plan. Additionally, the appeal should be reviewed to determine if additional information (authorization form or designation of authorization form ("DOA"), if applicable) may be needed. Consideration should be made as to whether the request is an actual appeal of a claim (an appeal from the employee or a representative of the employee (via DOA form) vs. a basic request for reconsideration (provider appeal) and if the appeal was filed in accordance with the plan's filing limit for appeals. If the request is determined not to be within the timeframe to file an appeal, the AC should write the appellant to explain the filing

limit for appeal requests. **NOTE: All correspondence related to the appeal should be sent directly to the patient (if over 18 years old).**

3) If it is determined that the request is an appeal that was filed timely, the request should be reviewed, along with the claim payment record, all related phone docs, all related mail log images, eligibility notes and the claims workflow notes. The AC should request all related phone calls be pulled and transcribed by the customer service department.

4) Once all documents have been assessed, the AC will determine what other records may be needed to evaluate the appeal. If additional medical records will be required and the appeal was submitted on a NOA (Notice of Appeal) form, a system form letter –01- (additional information letter) is completed and printed. Mail the -01- letter and release for authorization form to the provider. The documentation system and the appeals spreadsheet should be updated as to what information is needed and from whom it was requested. If the appeal was submitted by letter, issue -01- letter to the provider requesting medical records , and mail an authorization form, with a cover letter, to the insured (The provider may submit the information requested without the authorization, however, if required by the provider, the request has already been made) The authorization form is located at Claims TPA\Appeal Documents\Forms & Templates\TPA Appeal Authorization Form (to the claimant) and cover letter is located at Claims TPA\Appeal Documents\Forms & Templates\TPA Appeal Authorization Letter Once the signed authorization is received, resend the -01- letter along with the signed authorization form to the provider if the medical records have not been received.

5) If medical decision-making is involved, the claim should be routed to a nurse reviewer, unless it has already been reviewed for medical necessity by an outside reviewer and in that case, should be sent back to the original reviewer. If the nurse cannot make a determination, the case should then be referred to the Claims Risk Coordinator for submission to the appropriate outside reviewer. In some cases, the medical review may provide resolution to the claim appeal because of newly received information.

6) The appeal request is also reviewed to ensure that the original claim was processed correctly or to see if there may be new information that would change the original benefit determination on the claim. To obtain the review of another member of the claims department, formulate the question on the phone doc record and route the question to the CSL. The phone doc record should be updated to reflect the current status of the appeal. If the AC determines the claim was processed incorrectly, the appeal request should be forwarded to the Manager, Claims Risk Management before proceeding further.

7) If a review of the appeal determines that the claim is payable, the claim should be forwarded to a CSL for adjustment. Once the claim has been adjusted, the CSL should pend the phone doc back to the AC, who will update the appeals spreadsheet and notify the Executive Administrator of the outcome. The AC will issue a letter advising the insured that the appeal request has been resolved and the claims adjusted. This letter is reviewed by at least one other member of the Claims Department prior to being mailed; this review ensures the letter is being mailed to the appropriate insured.

8) The AC will prepare a Facts, Issues, Rules, Application and Conclusion (FIRAC) form, which will be presented to the Appeals Committee (along with other supporting

documentation).., The FIRAC form is a word document that can be found atClaims TPA\Appeal Documents\Forms & Templates\Mutual FIRAC Form

9) Approximately two weeks before the Appeals Committee meeting, pre-appeals committee meeting will take place with the Manager of Claim Risk, Director of Claims, Vice President of Administrative Operations and Vice President of Compliance. (The appeals packet should be given to these individuals for review 1-2 days prior to the meeting.) This group will review the appeals to ensure that they need to be presented to the Appeals Committee. For any appeal that this group feels do not need to be heard by the Appeals Committee, the AC will notify the CSL to adjust the claims and respond to the appellant (refer to #7 above). Otherwise the appeal will be finalized for presentation to the committee members.

10) The Appeals Committee typically meets once per month, depending upon the number of appeals that need to be heard. Following the pre-appeals meeting, all appeals that will be heard by the Committee will be prepared into a packet and sent to every committee member approximately five (5) days prior to the meeting. . A cover memo is also included that lists the names of each appeal and the date and time of the meeting. A copy of the packet should also be given to the Executive Administrator A copy of any changes made to the appeals packet during the pre-appeals meeting will be sent to the V.P of Compliance, the V.P of Administrative Operations, the Director of Claims, the Manager, Claims Risk Management, the Appeals Coordinator..

11) After the Appeals Committee meeting, the FIRAC is completed with the addition of the conclusion and forwarded to the Executive Administrator for filing. The AC should also schedule the next pre-appeals meeting and the Appeals Committee meeting.

12) If the appeal request is denied, send denial letter located under: H\Claims TPA\Appeal Documents\Forms & Templates\Denial letter for appeals. A copy of the plan's supporting language, along with the external review rights and the plan's additional appeal rights, should be sent with the denial letter. This letter is reviewed by the Manager, Claims Risk Management for content (prior to being mailed) to ensure the letter is being mailed to the appropriate insured.

13) If the appeal request is approved, then the claims in question are forwarded, via the phone documentation system to the appropriate CSL for adjustment. The AC will issue a letter advising the insured that the appeal request has been approved. This letter is proof read by the Executive Administrator then printed and given to the Manager, Claims Risk Management for review of content (prior to being mailed) to ensure the letter is being mailed to the appropriate insured.

14) Once the appeal is completed, the documentation system is coded AA-appeal approved, AD-appeal denied, AR-appeal resolved (when an appeal is handled without having to go through the formal appeal process) or AW-appeal withdrawn. The appeals spreadsheet should be updated at this time.

15) A copy of the disposition letter is given to the Executive Administrator for filing.

16) The complete FIRAC packet should be sent to be scanned.

17) On the first of each month, send an email to the Executive Administrator indicating the open appeals, to be compared to ensure all appeals have been handled.

Outputs
FIRAC packet
Response letter to insured/member
Explanation of Benefits
Appeals Spreadsheet

Measurements related to this process

Refer to departmental turn-around time requirements.

Forms / Records

Refer to departmental listing of records.

Rev.	Identification of Change	Author/Approver	Revision Date
1	Converted to new form	Amber Mitchell/ Bobbie Painter	09/01/2005
2	Revised **Inputs**. Revised **Process** steps #1-#15	Amber Mitchell/ Bobbie Painter	01/24/2012
3	#1 Changed location of form. #4 Revised process and changed for location. #5 revised process. Move step 8 to step 10 and changed process. Revised process steps #11 - #14. Add #18. Add flow chart.	Stefanie Kirkpatrick/ Bobbie Painter	7/17/2014
4	Changed #12 add location of denial letter Changed #16 wording to include complete FIRAC scanned. Remove Flow Chart	Stefanie Kirkpatrick/ Bobbie Painter	10/2/14
5	Updated Input section for Indiana DOI turnaround time requirements; Revised #2 to clarify the DOA is not required to move forward. Also all correspondence goes to patient if over 18 yrs old	Stefanie Kirkpatrick/ Bobbie Painter	06/06/2016
6	Under Indiana Dept Ins section add insured has 120 day for external review and cost is paid by MedBen	Stefanie Kirkpatrick/Bobbie Painter	8/12/16

MedBen Work Instruction
Independent Review

Author's Name/Title	Stefanie Kirkpatrick/Manager, Claim Risk
Department Covered by Work Instruction	Claims Processing
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Approved by:	Bobbie Painter
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Purpose of Work Statement
To establish a work instruction for the process of sending an Independent Review for Appeal purposes.

Inputs
When a request is received on an appeal to use an Independent Reviewer regarding medical necessity.

Process
When a determination is made on an appeal and the Covered Person does not agree, they may be entitled to an independent review by an independent review organization (IRO). Review the plan document to determine if they are eligible for an external review:

1. For Indiana fully insured, and Indiana non-ERISA self-funded groups that have adopted the Indiana external review provision, you will need to go to the following link http://www.in.gov/idoi/2690.htm to select an approved IRO. Selection of the IRO from this list must be done sequentially without repeating until the entire list has been used (unless the IRO has been previously involved in reviewing the case, does not have the necessary expertise to make the determination or any conflict of interest described in **IC 27-8-29-13(d) exists**). You will need to verify with the Compliance Department, which IRO MedBen is contracted with before sending the review request.

   The following procedures must be followed:

   a) a covered individual or a covered individual's representative may file a written request with for an external grievance review of the insurer's appeal resolution within one hundred twenty (120) days after the covered individual is notified of the appeal resolution;

   b) an expedited external grievance review should be provided for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's life or health or ability to reach and maintain maximum function. The external grievance review and the notification of the covered person as to the decision of the IRO must be made within seventy-two (72) hours of the request;

   c) a standard external grievance review for a grievance not described in 2) above must be completed by the IRO within fifteen (15) days of the request, and MedBen must notify the covered person of the decision of the IRO within seventy-two (72) hours of such decision.

   d) a covered individual may file not more than one (1) external grievance of an insurer's appeal resolution.

   e) MedBen shall monitor the deadlines required of the independent review

organization selected (as described above).

f) If at any time during an external review, the covered individual submits information to MedBen that is relevant to the resolution of the covered individual's appeal of a grievance that was not considered by MedBen prior, MedBen may reconsider the resolution and the independent review organization shall cease the external review process until MedBen has made its reconsideration. MedBen shall reconsider the resolution based on the information and notify the covered individual of our decision:

   i. within seventy-two (72) hours after the information is submitted, for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the covered individual's life or health or ability to reach and maintain maximum function; or

   ii. within fifteen (15) days after the information is submitted, for a reconsideration not described in (i.) above.

g) If the decision reached is adverse to the covered individual, the covered individual may request that the independent review organization resume the external review. If MedBen chooses not to reconsider the resolution, we will forward the submitted information to the independent review organization no more than two (2) business days after the receipt of same.

2. For Ohio fully insured, and Ohio non-ERISA self-funded groups that have adopted the Ohio external review provision, you will need to go to the following link https://legacy.insurance.ohio.gov/Classic/Company/scripts/irosel1.asp fill in the fields and an IRO will be selected for you to use.
3. For all other states, you will need to contact the Compliance Department for direction in selecting an IRO.

If the determination is upheld by the IRO, you will send a letter to the claimant advising of the external review determination. If the IRO has reversed the decision, the appropriate action will need to be taken (e.g. claim adjusted, approval letter sent if prior-auth).

Outputs
Medical Records
Signed Release of Information
Section of Plan relative to appeal

Measurements related to this process

Refer to departmental turn-around time requirements.

Forms / Records

Refer to departmental listing of records.

Rev.	Identification of Change	Author/Approver	Revision Date
1	Updated website link to Ohio's IRO vendor selection	Stefanie Kirkpatrick/ Bobbie Painter	04/05/2016
2	Update for Indiana fully-insured timelines and requirements	Stefanie Kirkpatrick/ Caroline Fraker	6/9/2016